STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
BOX 942732
SACRAMENTO, CA 94234-7320
(916) 322-1584

Date Issued: January 16, 1996
CMSP Letter: 96-3

To: All County Medical Services Program (CMSP) County Welfare Directors

Subject: REVISED CMSP MEDICAL CARE HEARING REQUEST
(FORM CMSP 1175)

This letter transmits two camera ready copies of the revised County Medical Services Program Medical Care Hearing Request (Form CMSP 1175). Counties should use these camera ready masters to produce a prudent supply of these revised forms. Previous revisions of these forms should no longer be used.

If you have any questions about this letter please contact Ms. Genny Fleming of my staff at (916) 327-3867. Thank you for your attention to this matter.

Sincerely,

Jim Martinez, Chief
County Medical Services Program Unit

Enclosures

cc: Mr. Albert Cooper
Office of County Health Services
Department of Health Services
1800 3rd Street, Room 100
P.O. Box 942732
Sacramento, CA 94234-7320

COUNTY MEDICAL SERVICES PROGRAM (CMSP)
MEDICAL CARE HEARING REQUEST

INSTRUCTIONS

If you are dissatisfied with any decisions regarding medical care under the County Medical Services Program (CMSP), you have the right to request a hearing by the State Department of Social Services. (If you are dissatisfied with any decisions regarding eligibility for the CMSP, please contact your county welfare department.)

Your request for a hearing may be written or oral. *Your request for a hearing must be made within 90 days of the date on which the problem occurred.* The State Department of Health Services will review your hearing request and may contact you.

To file a written request for a hearing about medical care, follow these steps:

1 Please fill in the information requested and provide your signature on the back of this form.

2. Send the completed and signed form to:

Office of Chief Referee
State Department of Social Services
744 P Street, Mail Station 19-37
P.O. Box 942732
Sacramento, CA 94234-7320

To file an oral request for a hearing about medical care, call the Public Inquiry and Response Unit at 1-800-952-5253. (Toll-free number.)

You may have witnesses at the hearing.

You will receive a written copy of the State Department of Health Services' position two days before the hearing.

You will receive a written copy of the decision.

You have the right to be represented at the hearing by another person of your choice (an attorney, a friend, a relative, or other spokesperson). You may be able to receive legal advice by calling the nearest legal assistance/services agency.

INFORMATION PRACTICES ACT STATEMENT

The information requested on the back of this form will be used by the State of California to resolve your complaint regarding medical care provided under the CMSP. Completion of the form is voluntary, and the form should be submitted to the State Department of Social Services if you wish to request a state hearing. All information you submit is confidential, and it will be provided only to the State Department of Health Services and your county welfare department. For more information regarding use of this information or access to your records, contact the Office of County Health Services, State Department of Health Services, P.O. Box 942732, Sacramento, CA 94234-7320 (telephone (916) 322-1086).

(Over)

1. Request for hearing (complete information below)

_____ daytime phone _____
Name

address _____, hereby request a hearing of actions taken by the State Department of Health Services regarding benefits and services under the County Medical Services Program (CMSP).

2. Complaint (explain your complaint about medical care under CMSP. Attach additional sheets if necessary.)

3. Complaint Date(s) (enter the month/day/year the problem occurred.)

4. Name of the Health Care Provider (HCP) (doctor, pharmacy, hospital) Involved	6. HCP Phone Number
5. Address of HCP	

7. Name of Your County Welfare Department Worker	8. Phone Number
9. Beneficiary ID Number (enter your ID number located on the fourth line, upper left-hand corner of your CMSP card) ___ ___ / ___ ___ / ___ ___ ___ ___ ___ ___ ___ / ___ / ___ ___	10. Date Valid

The information I have given here is complete and accurate to the best of my knowledge. The State Departments of Social Services and Health Services have my permission to obtain information about my case from the county welfare department and/or the health care provider.

Signature	12. Date